TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Amita Hegde, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-1858-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED TO DATE"

Amount in Dispute: $1415.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The date on the narrative report of the MMI/IR exams is 7/22/15…

The date on the DWC69 is 7/22/15…

The billing date of service is listed as 7/31/15…

Due to the inconsistency between the bill and the documents that are supposed to substantiate the bill, Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2015	Designated Doctor Examination	$1415.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for completing a medical bill.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 249 – DWC-73 not submitted; not properly completed and/or missing doctors signature; reimbursement denied per rule 129.5.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 892 – "DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS."

28 Texas Administrative Code §133.10(f)(1)(O) requires that the billing claim form include the date of service. 28 Texas Administrative Code §134.204(j)(1)(D) requires that a narrative report accompanies the billing of an examination for maximum medical improvement and impairment rating. Review of the submitted information finds that the narrative report does not support the date of service billed. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	April 15, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.